ALL TASK FORCE ADOPTED RECOMMENDATIONS LISTED BY TOPIC[1]

Recommendations were adopted in the followings areas:

Adopted Recommendations

1. IMPROVING REGULATION
a. Government Regulation of Managed Care

Recommendation No. 1 Streamline Regulatory Oversight

(a) A new state entity for regulation of managed health care[2] should be created to regulate health care service plans currently regulated by the Department of Corporations [DOC] and to phase-in the regulation of other entities over time, consistent with these recommendations (1.a-f). Appropriate health staff of the DOC will be transferred to the new regulatory entity.

(b) Medical groups and other provider entities that bear significant risk should be directly regulated by the new state entity for solvency and quality. Within a year, the Governor and Legislature should study and recommend to the public as to the method for consolidated, direct regulation by this new entity, of medical groups/IPAs and other provider entities in the state that are not currently directly regulated and who bear significant risk, on the basis of solvency and quality, to the extent they can be shown to be contributing to medical decisions (i.e., not coverage decisions determined contractually by an employer).

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[1] The Task Force adopted recommendations in three core areas [No. 1 through 3]. Listed under each area are a number of topics which correspond to the titles of individual Findings and Recommendations Sections adopted by the Task Force in November and December 1997 [idenitifed with a lower case letter of the alphabet].

[2] Task Force members suggested through an informal questionnaire that the new entity be named, if led by a board, the "California Managed Care Authority (CMCA)" or, if led by an individual, the "California Office of Health Care Oversight (COHCO)". More appropriate names might include reference to a Board (e.g., the California Managed Care Board) or to a Department (e.g., the California Department of Health Care Oversight) respectively.

(c) Within one year, the Governor and the Legislature should study the feasibility and benefit of consolidating the health care quality review functions of all state governmental agencies within the new entity.

(d) Within two years, the Governor and the Legislature should study the feasibility and benefit of consolidating into the new state entity the regulation of other health insurers providing insurance through indemnity, PPO and Exclusive Provider Organization (EPO) products currently regulated by the Department of Insurance [DOI].

(e) Subsequently, the merits of folding into the new state entity other regulatory functions (e.g., those that regulate providers, clinicians, and medical facilities) should be examined. However, further consolidation should be phased-in in a manner that minimizes disruption of essential regulatory functions. Any proposed consolidation should weigh the potential benefit and detriment to the public and consider the impact on the stability of the organization.

(f) Any health-related regulatory authority or related government entity not incorporated into this new state entity should develop enhanced electronic capabilities to share information and work together with other oversight entities.

Recommendation No. 2 Provide Appropriate Leadership

(a) The new oversight organization should be led either:

(1) by a board that would review and approve major policy and regulatory matters, comprised of five or more individuals having specified qualifications, appointed to staggered terms, with a majority appointed by the Governor and at least one member each appointed by the Assembly and the Senate, working with a full-time Chairperson of the Board who has day-to-day operating responsibility and authority and who is an individual of stature in the health services field who can command respect and exercise strategic leadership, appointed by Governor, or

(2) by an individual of stature in the health services field who can command respect and exercise strategic leadership, appointed by the Governor and confirmed by the Senate.

In either case, the leadership of the organization should have a sympathetic understanding of the problems of patients and their families and an understanding of the health care market.

(b) An advisory committee should be established that includes the leaders of other health regulatory agencies as ex-officio/non-voting members, health care experts, and stakeholders.[3]

Recommendation No. 3 Adopt Appropriate Principles for Regulation

The following principles should guide regulation by the oversight entity: (a) regulation should be as efficient and streamlined as possible, (b) regulation should be conducted in cooperation with other public and private bodies that also regulate or purchase from health care service plans and other health insurers to the maximum extent possible, and (c) regulation should recognize and expedite approval of beneficial innovations (i.e., those that consumers want, improve quality, or save costs without causing harm), (d) regulation should be fair, predictable and strictly enforce the laws to ensure high quality standards are met and that low performers improve or be removed from the pool of choices available to consumers.

Recommendation No. 4 Streamline Regulation of Medical Groups/IPAs

[3] The intention of the Task Force is that stakeholders include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.

The state entity for regulation of managed care should be given the authority and responsibility to facilitate the existing oversight of medical groups, IPAs and other entities that enter into risk contracts with Knox-Keene regulated health plans, including as priorities solvency and quality audits (as described below) but also considering oversight of other issues such as the credentialing process, monitoring of provider compensation arrangements and their disclosure, dispute resolution processes, and other areas if necessary. This oversight should be exercised in a way that would reduce cost for providers and health plans. For example, the regulatory authority should consider and work together with ongoing streamlining efforts of accreditation and other private organizations.

Recommendation No. 5 Streamline Solvency Audits

Currently, health plans audit provider organizations to determine whether they are fiscally solvent and capable of assuming risk. This creates burdens for provider organization that might contract with many different plans and difficulties because health plans may seek information that medical groups consider proprietary.

(a) In order to facilitate the development of this information in a manner that is less burdensome, a provider organization should be able to request that the state entity for regulation of managed care oversee one solvency audit on a periodic basis that would meet the requirements of all contracting health plans.

(b) The state entity for regulation of managed care may contract, where appropriate, the authority to audit provider organizations by subcontracting with independent, third-party organizations, such as accounting firms, that meet standards the regulatory entity establishes through a competitive process.

(c) The oversight entity should convene a stakeholder-working group, including provider organizations that contract with multiple health plans and the health plans with which they contract to develop acceptable, specific solvency standards and financial documentation. The solvency standards may vary by size and type of organization, amount of risk assumed, or other pertinent factors.

Recommendation No. 6 Streamline Quality Audits

In order to comply with Knox-Keene standards for health plan quality, health plans must audit the quality of the provider organizations with which they contract.

(a) In order to facilitate the collection of standardized data and quality processes necessary to audit quality in an efficient manner, a provider organization should be able to request that the state entity for regulation of managed care oversee one quality audit of that data on a periodic basis (e.g., annually) that would determine compliance with the quality standards of all contracting health plans. The regulatory authority would need to provide that the audits establish whether provider organizations treat different plan members differently. When standardized data is not available, health plans may use other information to ensure quality of care.

(b) The state entity for regulation of managed care may contract, when appropriate, for audits of medical groups with independent, qualified, third-party organizations that meet standards the state entity for regulation of managed care establishes.

(c) The cost of the single quality audit should be shared among all the health care service plans with which a provider organization contracts. This would save health care service plans and providers time and money.

Recommendation No. 7 Adopt Principles for Public/Private Collaboration

The Task Force makes numerous recommendations that encourage state entity(ies) for regulation of managed care and for data collection to work in collaboration with, and not duplicate the efforts of,

private sector initiatives and the data collection efforts of private purchasers or accrediting bodies. The Task Force endorses these efforts to the extent the following are satisfied, where the private activity is being conducted to accomplish a public purpose:

(a) There must be full disclosure upon request of all survey processes, methodologies and investigative results—the data collection protocols and results should be publicly available to the same extent they would be if the effort were conducted by the state entity itself.

(b) Private data collection standards, protocols and results of data collected must be available to the public in a timely manner at no or low cost to the extent that data satisfies public oversight requirements. The cost (if any) to the public should be nominal and reflect only the costs of copying and distribution.

(c) The collaboration with private entities by the state regulatory bodies should not limit or impede the public processes by which the state determines which data should be collected and how quality should be monitored.

(d) The state entity for regulation of managed care or other appropriate agencies should ensure that any privately collected results relied upon by the state to satisfy its requirements are valid.

Recommendation No. 8 Promote Inter-departmental and Private Sector Coordination and Eliminate Redundancy

Until oversight is consolidated, government departments, in addition to the state's managed care regulatory authority, that regulate health insurers that offer indemnity, PPO, and EPO products (e.g., DOI, US DOL) or oversee health services for different populations (e.g., Department of Health Services, [DHS], Division of Workers' Compensation, US HCFA), should coordinate activities and streamline information sharing. The state entity(ies) for regulation of managed care should also coordinate with private sector quality measurement and accreditation bodies to develop solvency, accounting and quality standards to ensure that they satisfy their respective requirements with regard to the scope of issues covered by the audit.

Government departments should seek to avoid duplication of audits conducted by independent third-party, government-approved auditors. Carriers that are in the business of both indemnity insurance and HMO coverage should not be subjected to duplicative business audits by the Department of Insurance and the new state entity for regulation of managed care. Health insurers offering indemnity, PPO, and EPO products should be subject to regulatory review by other departments only in those areas where the program differs from Knox-Keene Act requirements or exceeds those requirements.

Recommendation No. 9 Meet the Challenges Presented by Accelerating Industry Change

(a) The state entity for regulation of managed care should define and publish formal policies and procedures regarding filing formats, filing requirements, interpretive guidelines for plans and counsel regarding how requirements apply in critical areas, and an approval process that contains quality control and "consistency control" checks. With criteria set up front, health care service plans could plan effectively and modify applications to improve likelihood of approval. Furthermore, with standard decision criteria, the regulatory authority's regulators would become more efficient.

(b) The state entity for regulation of managed care should take steps to improve efficiency and consistency of its decisions. Steps may include the following: (1) upgrading information technology capabilities, (2) expediting the hiring of additional staff provided for by the budget augmentation, (3) setting guidelines for and requiring counsel to participate in training about policies and interpretations, (4) setting standards for health care service plan documents, (5) consistently assigning counsel to the same plans (but with enough rotation to inhibit conflicts of

interest), (6) reviewing workload allocations, and (7) educating staff about the health services industry and managed health care.

(c) Legislation should be passed that would allow health care service plans to consolidate minor amendments, as defined by the state entity for regulation of managed care, that occur during the year into one annual filing.

(d) The recent DOC budget augmentation should be evaluated to determine its impact on responsiveness and to assess the need for additional or reallocated funds, given proposed steps for streamlining.

(e) Health care service plans should be allowed to consider new product material modifications approved, if the state entity for regulation of managed care does not "act" as defined by Knox-Keene Act Section 1352(b) by approving, disapproving, suspending or postponing approval within a time frame (e.g., 60, 90, or 180 days) designated in advance by the regulatory entity. As under current law, any such order may not be issued without the approval of the supervising counsel and assistant commissioner. If the state entity for regulation of managed care requires changes to any aspect of the material modification after the designated period, the health care service plan should be required to make those changes prospectively, but should not be subjected to departmental disciplinary actions.

These recommendations were individually adopted by the Task Force as follows:

Recommendation No. 1(a) & (b) – Adopted 20-6
Recommendation No. 1(c) – Adopted 25-0
Recommendation No. 1(d) through 1(f) – Adopted 20-6
Recommendation No. 2 – Adopted 26-0
Recommendation No. 3 – Adopted 27-0
Recommendation No. 4 – Adopted 22-0
Recommendation No. 5 – Adopted 23-0
Recommendation No. 6 – Adopted 26-0
Recommendation No. 7 – Adopted 27-0
Recommendation No. 8 – Adopted 25-0
Recommendation No. 9(a) through 9(d) – Adopted 25-0
Recommendation No. 9(e) – Adopted 22-2

2. MAKING COMPETITION WORK FOR PATIENTS

a. Expanding Consumer Choice of Health Plans

Recommendation No. 1 Expand Choice of Plan

The Task Force recommends that public and private purchasers should, whenever feasible, offer consumers a choice of high quality health plans, including choices through purchasing groups where accessible. In addition, the US Congress and the California State Legislature should continue to seek ways to expand coverage and choices of plans.

Recommendations No. 2 and No. 3 Expand Purchasing Groups

The Task Force recommends that the state make it a matter of public policy to facilitate and encourage the development of purchasing groups (both marketing groups and purchasing alliances) for small and medium size employers. The applicable state entity for regulation of managed care[4] should work continuously to simplify the process of, and eliminate barriers to, purchasing group formation and make

[4] The Department of Corporations, the Department of Insurance, or their successor.

recommendations for changes to the Legislature if necessary. Appropriate measures for the DOC and DOI may vary.

The Task Force recommends that guaranteed issue, plan design disclosure, and premium rating limitations for employers with 51-100 employees like those in effect for the 2-50 group market be enacted so that purchasing groups can form, flourish, and obtain a wide variety of participants in the mid-size market, protected from the adverse selection they would be likely to suffer without these provisions.

Recommendation No. 4 Expanding Access to Providers and Treatment
A working group of stakeholders[5] should be convened to examine the issue of how to increase consumer choice of providers on a cost neutral basis.

These recommendations were individually adopted by the Task Force as follows:
Recommendation No. 1 -- Adopted 24-0
Recommendation No. 2 -- Adopted 23-0
Recommendation No. 3 -- Adopted 17-7
Recommendation No. 4 -- Adopted 23-2

b. Minimizing Risk Avoidance Strategies

Recommendation No. 1
The Task Force recommends that the CalPERS Board of Administration be urged that CalPERS, preferably in combination with the University of California and PBGH, with its nearly three million members, take the lead in introducing risk adjustment to the California market. The Task Force recommends implementation of a state-of-the-art (i.e., to the degree they have significant predictive power, diagnosis, socio-economic, and other variables) risk adjustment system within three years. CalPERS should report to the Legislature in two years, including its progress toward risk adjustment, the cost implications, any concerns about patient privacy, and a recommendation to proceed or not to proceed and why. The Task Force believes this would be in the best interests of California public employees, and would be a great public service to the people of California.

Recommendation No. 2
The California Department of Health Services (DHS) should be instructed to seek to join with the Health Care Financing Administration (HCFA, administrator of the Medicare and Medicaid programs) in a cooperative project with beneficiaries to explore expanded efforts to do risk adjustment for services to Medi-Cal beneficiaries. DHS should be required to report in two years, including its progress toward risk adjustment, the cost implications, any concerns about patient privacy, and a recommendation to proceed or not to proceed and why.

Recommendation No. 3
Similarly, DHS should be instructed to participate in HCFA-sponsored risk adjustment demonstration projects for managed care plans serving Medicare beneficiaries as and when such demonstration projects are proposed.

Recommendation No. 4
The Task Force recommends that the state explore with the federal Office of Personnel Management a California pilot project for risk adjustment of premiums for health plans serving federal employees in California in the Federal Employees Health Benefits Program (FEHBP).

[5] The intention of the Task Force is that stakeholders include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.

Recommendation No. 5
Upon implementation by CalPERS of a risk adjustment mechanism, requiring all purchasing groups to risk adjust payments to participating plans within a reasonable timeframe should be considered.

Recommendation No. 6
As soon as technically feasible, health plans should be required as a matter of licensure to risk adjust payments to their at-risk, contracting, treating providers in addition to using other mechanisms that appropriately compensate for risk (e.g., stop loss coverage, carve outs, global case rates); and when premiums are risk adjusted, to flow through those risk adjustments to the at-risk, treating provider as well.

Recommendation No. 7
Major purchasers, including the state, and foundations are strongly encouraged to make moving forward the science of risk adjustment (and the ability to monitor its impact on clinical outcomes for different populations) a high priority through funding and support.

Recommendation No. 8
The state entity for regulation of managed care[6] should be charged with overseeing these efforts and reporting on progress annually to the Legislature and Governor.

These recommendations were individually adopted by the Task Force as follows:
Recommendation No. 1 – Adopted 17-0
Recommendation No. 2 – Adopted with 20 affirmative votes
Recommendation No. 3 – Adopted 19-0
Recommendation No. 4 – Adopted with 20 affirmative votes
Recommendation No. 5 – Adopted with 17 affirmative votes
Recommendation No. 6 – Adopted with 19 affirmative votes
Recommendation No. 7 – Adopted with 20 affirmative votes
Recommendation No. 8 – Adopted with 19 affirmative votes

c. Standardizing Health Insurance Contracts

Recommendation No. 1
The state entity(ies) for regulation of managed care should be directed to adopt a pro-active policy toward the development of standard referencehealth plan contractsthat can be used by buyers and sellers by reference, that health plans can offer on a fast track basis through the regulatory process.

Recommendation No. 2
(a) The state entity(ies) for regulation of managed care should be directed to develop a set of five (5) standard referencehealth plan contractsin each of the HMO, POS, PPO, and indemnity product lines, from minimal to comprehensive, that can be used by buyers and sellers in the small group and individual markets along with explanatory materials to help buyers understand their choices.

(b) This should be done in consultation with the Major Risk Medical Insurance Board, and stakeholders.[7]

(c) On a biennial basis, the state entity(ies) for regulation of managed care should re-examine standard contracts and adopt modifications as appropriate.

[6] The term "state entity for regulation of managed care" refers to the Department of Corporations or its successor.
[7] The intention of the Task Force is that stakeholders include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.

(d) Small business would not be required to limit its choices to these standard packages, but in addition would be able to select any other contract health plans offered. In effect, approval by the state entity(ies) for regulation of managed care for the standard contracts would be "fast-tracked."

(e) Health plans should be required to publish and provide upon request by employers or consumers, a clear and concise comparison between any product they offer in the small group or individual market and one of the reference contracts.

Recommendation No. 3

(a) The state entity(ies) for regulation of managed care should be authorized and directed to convene a working group to develop a standard outline and definitions of terminology for evidence of coverage (EOC) and other documents to facilitate consumer comparison and understanding.

(b) The working group should include the major stakeholders and should build on previous accomplishments by organizations such as the California Public Employees Retirement System, Pacific Business Group on Health, and the Health Insurance Plan of California. The regulatory entity should convene the working group on a biennial basis to consider modifications.

(c) When consensus has been achieved, the regulatory entity should promulgate proposed rules for consideration and adoption, subject to notice and comment proceedings.

These recommendations were individually adopted by the Task Force as follows:
Recommendation No. 1 -- Adopted with 19 affirmative votes
Recommendation No. 2(a) thru (d) -- Adopted with 19 affirmative votes
Recommendation No. 2(e) -- Adopted with 16 affirmative votes
Recommendation No. 3 -- Adopted with 25 affirmative votes

d. New Quality Information Development

Recommendation No. 1 Transition from a Statutory to a Regulatory Approach to Data Collection

(a) The Task Force recommends that the state health data programs be given the authority to request specific new data elements from health plans and providers to support new quality measurement initiatives. Broad data guidelines should be set by the Legislature, but the state programs should be given the flexibility to innovate. The state entity(ies) for regulation of managed care[8] should approve data requests (e.g., data elements) and make specific findings regarding cost and benefits.

(b) The state entity(ies) for regulation of managed care should be authorized to convene an advisory body composed of stakeholders[9], to evaluate specific data requests. Such requests should balance the cost and value of information to be provided. Redundant information requests should be reconciled. The advisory body should encourage data requesters to employ valid and reliable statistical sampling techniques when feasible. The state entity(ies) for regulation of managed care should coordinate data requests from all requesters to avoid duplication.

Recommendation No. 2 Advance Implementation of Electronic Medical Records

The Task Force recommends that the state entity(ies) for regulation of managed care be aware of, participate in, and actively help where possible, ongoing private and public sector efforts, such as those that have been initiated collectively by Pacific Business Group on Health (PBGH), National

[8] The state entity(ies) for regulation of managed care refer to DOC, DOI, or their successor.
[9] The intention of the Task Force is that stakeholders include, but are not limited to, consumers groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.

Independent Practice Association Coalition (NIPAC), American Medical Group Association (AMGA), California Medical Association (CMA), California Healthcare Association (CHA) and California Association of Health Plans (CAHP), to develop standardized eligibility, enrollment and encounter data.

(a) The state entity(ies) for regulation of managed care should strongly encourage, by providing leadership and coordination, that components of electronic medical records (starting with encounter data), based on systems that permit easy sharing and exchange of data be phased in with a target date of 2002-2004 depending on the size and resources of the medical group/IPAs, health plans, clinics and hospitals.

(b) This strategy should include strict provisions for maintaining patient privacy and confidentiality including fire walls between individual patient data and employers. The state entity(ies) for regulation of managed care should impose severe penalties for individuals or organizations if they abuse the release of individual patient data. (See also the Task Force paper on Physician-Patient Relationship).

(c) The Task Force recommends to the President and the U.S. Congress that the federal government should assume responsibility for establishing technical standards for electronic communication of health care information (such as uniform identifiers for patients and providers and uniform language and data definitions), standards for confidentiality and standards for information security. Federal initiatives in these areas will help ensure compatibility and comparability of information across states. This will assist the study of health outcomes regionally and nationally.

Recommendation No. 3 Collect Health Information at the Treatment Level

(a) The Task Force recommends that health care information be collected and disseminated not only at the health plan level, but at the treatment level including hospital, clinic, medical group/IPA, ambulatory center, home health and nursing home levels. Information should emphasize and compare outcomes whenever possible and make specific findings as to the value and the cost of the collection and dissemination of the data. (See the Task Force paper on Consumer Information, Communication and Involvement.) Information should be reported by local geographic area where people are likely to seek and receive health care services. The state entity(ies) for regulation of managed care should either disseminate the above health plan and treatment level information to the public or assure that private dissemination of this information occurs and is widely available and easily accessible.

(b) The Task Force recommends that the state entity(ies) for regulation of managed care be aware of, participate in and actively help where possible, ongoing private sector efforts to develop and distribute these data.

Recommendation No. 4 Ensure Basic Safety Standards for Patient Care

The Task Force recommends that the state entity(ies) for regulation of managed care in coordination with OSHPD and DHS, create a blue ribbon panel (to include stakeholders and private accrediting organizations such as JCAHO and NCQA) to study and report by June 1, 1999 on ways to help improve patient safety in health care by reducing errors, adverse events and adverse outcomes. Specific areas to study should include variations in number and rates of adverse drug events, hospital and surgical infection rates, patient falls and pressure ulcers, and variations in risk-adjusted mortality and morbidity rates for major surgeries and treatments.

These recommendations were individually adopted by the Task Force as follows:
Recommendation No. 1 –- Adopted 21-0
Recommendation No. 2 –- Adopted 19-2
Recommendation No. 3 –- Adopted 17-1
Recommendation No. 4 –- Adopted 24-0

3. IMPROVING QUALITY OF CARE
a. Improving the Dispute Resolution Process

Recommendation No.1 Collaborative Development and Non-Duplication of Effort

Any of the recommendations below would benefit from a collaborative process in which the state entity(ies) for regulation of managed care,[10] health plans, purchasers, providers, consumer advocates and other stakeholders[11] form a working group to develop the detailed terms of the proposal. In addition, many recommendations reflect existing law applied to specific populations (e.g., Medicare or Medicaid), to those health plans regulated by Knox-Keene, or standards privately developed (e.g., by accreditation bodies). Where requirements already exist, we recommend building on existing standards rather than creating completely new ones. Similarly, recommendations are intended to recognize and build on existing community resources.

Recommendation No. 2 Broad Application

The Task Force recommends that the recommendations in this paper apply broadly.

(a) The Task Force strongly encourages voluntary adoption and implementation of the recommendations and existing law and relevant accreditation standards by purchasers, employers, and plan administrators in those situations where ERISA preemptions restrict the regulation and oversight of health plan processes.

(b) The Task Force recommends that employers voluntarily include Task Force dispute resolution standards and those set forth in existing law and relevant accreditation standards in contract obligations for health plans.

(c) The Task Force recommends that the US Department of Labor, to the maximum extent feasible under federal law, amend its regulations, procedures and oversight pertaining to employer-sponsored ERISA health benefit plans to conform to (or, if not legally feasible, at least complement) California's implementation of Task Force dispute resolution recommendations and existing law and relevant accreditation standards. The state's entity for regulation of managed care should be directed to take the lead in consulting and coordinating with the US Department of Labor to facilitate this goal.

Recommendation No. 3 Consistency and Common Standards for Internal Plan Grievance and Appeals Processes

The Task Force recommends that consistent standards regarding dispute resolution processes for all health plans be developed and adopted, to the extent the power exists to do so. The development of these standards should include consultation with health plans, medical groups/IPAs, consumers, consumer advocates, regulators, and other stakeholders. The goal of these deliberations should be to establish mandatory complaint processes that encourage resolution as close to the point of service as possible, to structure balanced and efficient processes, and to elicit reporting that is comparable and equitable. Those standards should include (where they are not already required) the following:

(a) Application to Provider Groups. If a medical group/IPA or other provider organization provides services to a health plan's member or enrollee, the provider group should meet the statutory

[10] The term "state entity(ies) for regulation of managed care" refers to the DOC or the DOC and DOI or its/their successor.

[11] The intention of the Task Force is that stakeholders include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.

standards required of health plans, as required under current Knox-Keene law. For example, timing requirements would include complaint processing time at the medical group/IPA level.

(b) Timing Requirements. Turn-around time for resolving complaints at all levels of the dispute resolution process should be consistent, with time adjusted for severity of problem.

(1) Currently, Knox-Keene regulated health plans are required to resolve whenever possible and respond to non-urgent grievances within 30 days.[12,13] The Task Force recommends that all plans (e.g., including non-Knox-Keene plans) be required to resolve non-urgent complaints within 30 days, except under special circumstances (e.g., when complex medical issues need to be researched), when the time frame may be longer.

(2) Currently Knox-Keene regulated health plans must resolve or respond to urgent complaints (defined as a situation in which the standard time frame could jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function as determined by a physician) within five days.[14] The state entity for regulation of managed care should examine this requirement and recommend (and provide rationale) to the Governor and the Legislature within two years as to whether all plans should be required to respond within 72 hours (as required by the Health Care Financing Administration) instead of the five days currently required.

(c) Periods of Limitation. Currently, Knox-Keene regulated health plans have an affirmative obligation to notify consumers of periods of limitations within which consumers must submit a grievance or appeal. These minimum periods of limitation should be standard across plans. The state's entity for regulation of managed care should establish minimum standards through a rulemaking. The ultimate minimum standard should include a provision for good cause exception. Periods of limitations should have no bearing on consumers' ability to access the state's entity for regulation of managed care for assistance.

(d) Communication of Processes. There should be consistency in how health plans inform consumers regarding how to use dispute resolution processes before and upon "grievable incidents." In addition, the state's entity(ies) for regulation of managed care, in consultation with health plans, should provide examples of well-prepared appeals for a variety of issues and make them available to consumers upon request.[15]

(e) Consumer Participation. Plans should provide opportunities for members to participate in the grievance process in person, at least at one time, to the extent possible.

(f) Full and Complete Explanations of Grievance or Appeals Decisions. If an in-plan physician's recommendation is denied by an organization (whether medical group/IPA or health plan), the physician should be notified and the patient should receive written notice, both of which should include the decision that was made, the reasons for the denial, the specific health plan contractual provision on which the decision is based (if applicable), the information that was reviewed in making the decision, any expert opinions or guidelines relied upon, and information and instructions on how to appeal the decision and timing.[16] Where explanations touch on

[12] Knox-Keene Act, Section 1368.01(a).
[13] Consumers enrolled in Knox-Keene regulated plans, after a 60-day period following submission of a grievance, are entitled to appeal to the Department of Corporations if their grievance remains unresolved at the plan level.
[14] Knox-Keene Act, Section 1368.01(b).
[15] The Knox-Keene Act currently requires the disclosure of the grievance system and the DOC hotline.
[16] When a Knox-Keene regulated health plan denies coverage for treatment, the plan must give the patient and provider the specific clinical criteria, if any, that was used in the denial (Section 1363.5).

quality of care issues, precautions should ensure that peer review processes are protected from intrusion.

(g) Terminology and Data Collection. The state entity(ies) for regulation of managed care should develop in collaboration with stakeholders, and phase-in with all deliberate speed, standard definitions to be used by health plans and the state entity(ies) for regulation of managed care for the meaning of terms commonly used in grievance processes, categories for reporting complaint types, and minimum standards for data collection by types of complaints.[17]

(h) Public Reports. Currently Knox-Keene plans must report complaints pending longer than 30 days, track their resolution, analyze the complaints, and use the information for quality improvement. In addition, after standard grievance terminology has been agreed (see recommendation 3.(g) above), the state entity(ies) for regulation of managed care should develop in collaboration with stakeholders and implement additional public reporting requirements (phased-in if necessary). Data reported to the state entity(ies) for regulation of managed care should be reliable and comparable, and the state entity(ies) for regulation of managed care should publish plan-specific and aggregate data on a periodic basis that should include data on all health plans. This data should be reported with the entity's(ies') own complaint and request for assistance data. In determining the amount and nature of the information to be reported, the state entity(ies) for regulation of managed care and stakeholders should consider, for example:

- aggregate numbers, types, length of time to resolution, and disposition of issues raised by condition or type of complaint, sorted by plan and medical group/IPA for groups over some size threshold (e.g., percent of enrollees, number of doctors, or top five groups per plan);
- a summary of the reasons decisions were upheld or overturned, including the basis upon which decisions are reached for particular types of complaints,[18] and
- the cost, comparability and validity of the data.

No such report should in any way impinge on patient confidentiality or peer review.

(j) Facilitate Consumer Contact With Regulators. The state entity(ies) for regulation of managed care should provide a single statewide "800" number that seamlessly transfers consumers to the appropriate agency.

Recommendation No. 4 Consumer Empowerment

To be educated and empowered, consumers in all types of plans need full information on their rights and how to exercise them. Information should include a "bill of rights and responsibilities" received on enrollment, describing the complaint processes (as is required under current law for Knox-Keene plans). Also, when a denial or "grievable incident" occurs, appropriate information should be provided to the patient. In order to avoid increasing legalistic aspects of physician-patient relationships and to prevent increasing paper flow, current law should be reviewed to ensure the following standards exist for all consumers:

[17] DOC has already developed common complaint categories for its hotline for the classification of types of complaints.

[18] The Task Force considered requiring plans to establish case-by-case precedents. While the Task Force believes that establishing consistency and making public the basis of health plan decisions, members think that requiring case-by-case precedents have limited applicability, could be overly burdensome on health plans, and potentially limit plans' discretion to resolve issues quickly and efficiently through compromise as close to the point of service as possible.

(a) Health plans and medical groups/IPAs should direct members to the appropriate next steps at every stage where a member expresses disagreement with a provider or plan decision as well as provide adequate explanation of the patient's rights and the basis of the decision.[19]

(b) If a patient disagrees with his or her health care practitioner, the patient should be given at least oral notice, (not necessarily in writing), of the availability of, and access to, a second opinion and the grievance process. When the decision of the medical group/IPA or plan differs from that of the patient's physician, the patient should be given oral notice, or written notice upon request.

(c) Health plans should be required to pay for second opinions from physicians within the consumer's health plan, and if there is no separate, qualified network provider, by a qualified out-of-network provider.

Recommendation No. 5 Consumer Assistance Through Plans

While the goal of the dispute resolution process should be to educate and empower consumers to be their own advocates, some consumers need assistance exercising their rights. Physicians can serve as important patient advocates. In addition, plans must have adequate internal systems and information to provide assistance. Such internal assistance may be particularly important for vulnerable populations. The Task Force recommends that private accreditation and quality audit standards, where applicable, should require plans to demonstrate support to consumers seeking to appeal, including coaching them on how to navigate the grievance process, adequate explanation of denial, and access to supporting documentation.

Recommendation No. 6

The Task Force encourages health plans to examine and adopt best practices as this will enhance member retention. Some exemplary efforts include the following:

- seeking the opinion of outside specialists in the relevant medical specialty for issues related to medical necessity or experimental and investigational treatments; and
- allowing members to attend reviews in person, or if the member can not (e.g., member is out of the area) or is not welcome to attend in person (e.g., member has a history of being abusive), by teleconference.

Recommendation No. 7 External Consumer Assistance

(a) The Task Force recommends that two pilot, independent external assistance or external ombudsman programs in different regions of the state be authorized, for which state funding should be secured. Such pilot programs should be used to assess how best to serve all health care consumers, how best to inform consumers of the existence of such external assistance programs, how to use existing assistance resources most effectively, and how to educate consumers to use (but not overuse) services. The pilot projects should include an evaluation of the potential impact on premiums and the value of the services to individual consumers and the health care system relative to the costs. The pilot programs should be coordinated with the Sacramento-area independent assistance program (the Health Rights Hotline), and with existing, targeted health care assistance programs (such as the Health Insurance Counseling and Advocacy Program (HICAP), the Long-Term Care Ombudsman program, and the US Department of Labor's evolving efforts to assist enrollees in employer-sponsored ERISA plans). They should complement and not duplicate existing services provided by health plans, other existing external resources, or regulatory bodies. The pilot programs should have common data collection and evaluation systems and publicly shared data regarding complaints to identify systemic problems.

[19] The Knox-Keene Act requires such notices at every stage.

Recommendation No. 8 Independent Third Party Review

The state entity for regulation of managed care should be directed to establish and implement by January 1, 2000 an independent third-party review process that would provide consumers and health plans with an unbiased, expert-based review of grievances pertaining to delays, denials, or curtailment of care based on medical necessity, appropriateness, and all "experimental-investigational treatments."[20] The specific details should be developed through a collaborative process, which should consider the following issues:

- whether access to independent review requires support of a provider in the consumer's health plan or any health professional;
- what should be the standard for decisions, and what should be considered expert evidence;
- how to ensure the decision-maker has adequate independence and appropriate expertise;
- what, if any, access thresholds (e.g., internal process exhaustion requirements, financial or "merit," seriousness of a case as determined by external guidelines, nominal fees) should apply.

Recommendation No. 9 Arbitration Standards

Health plans should be required to establish arbitration standards that include the following:

(a) Arbitration systems used by plans should provide for expeditious resolution of disputes, including rapid selection, or default appointment, of neutral arbitrators. Judicial intervention should not be necessary to ensure the appointment of arbitrators.

(b) An arbitration award should be accompanied by a written opinion. Copies of written opinions (excluding personal and confidential, and patient and provider identifying information), including award amounts, should be available to the public upon request through the state entity(ies) for regulation of managed care.

(c) The state entity(ies) for regulation of managed care should be authorized to prohibit a plan from requiring a party to continue to participate in arbitration if the plan was found by the regulator to have engaged in willful misconduct in the proceeding.

Recommendation No. 10 Assessment

Health plans, providers, foundations, consumer groups, etc., should be encouraged to assess the efficacy of the full range of dispute resolution mechanisms including, but not limited to, non-binding arbitration, mediation, and neutral fact-finders. The use of such mechanisms should be linked to publicly disseminated independent evaluation of how well they meet the principles set forth in the list of "Essential Elements" above.

These recommendations were individually adopted by the Task Force as follows:
Recommendation No. 1 – Adopted 16-0
Recommendation No. 2 – Adopted 20-0
Recommendation No. 3 & 3(a)– Adopted 19-0
Recommendation No. 3(b) – Adopted 20-0
Recommendation No. 3(c) – Adopted 23-0

[20] All Department of Insurance and Knox-Keene regulated health plans are required by AB 1663 to use an external review process for experimental treatments involving terminal conditions. California was a leader with this legislation.

Recommendation No. 3(d) – Adopted 24-0
Recommendation No. 3(e) – Adopted 22-1
Recommendation No. 3(f) – Adopted 25-0
Recommendation No. 3(g) – Adopted 23-0
Recommendation No. 3(h) – Adopted 22-0
Recommendation No. 3(i) – Adopted 21-0
Recommendation No. 4 – Adopted 22-0
Recommendation No. 5 – Adopted 23-0
Recommendation No. 6 – Adopted 26-0
Recommendation No. 7 – Adopted 20-0
Recommendation No. 8 – Adopted 22-0
Recommendation No. 9 & 9(a) – Adopted 20-2
Recommendation No. 9(b) – Adopted 16-2
Recommendation No. 9(c) – Adopted 18-7
Recommendation No. 10 – Adopted 23-1

b. Financial Incentives for Providers in Managed Care Plans

Recommendation No. 1

Health plans should be required to disclose to the public specific information about the scope and general methods of payment made to their contracting providers of health care services and the types of financial incentives used to enable consumers to evaluate and to compare plans. Disclosure should use clear and simple language, including a suggestion that if an individual wishes to know more about their providers' or provider groups' method of reimbursement, they can ask their medical group/IPA, provider, or health plan.

Recommendation No. 2

The state entity for regulation of managed care[21] should conduct a pilot project with a variety of health plans, their contracting medical groups, other provider groups, and consumer groups to develop clear, simple, and appropriate disclosure language (field-tested for consumer understanding and value) and the most cost-effective methods for distribution to enrollees. The state entity for regulation of managed care should report results back to the Legislature to consider how best to approach provider group disclosure.

Recommendation No. 3

Provider groups and health practitioners should be required to disclose the scope and method of compensation and financial incentives they receive, upon the request of a patient. Provider groups should also be required to disclose the methods of compensation and incentives paid to their subcontracting providers.

Recommendation No. 4

(a) Health plans and provider groups should be prohibited from adopting an incentive arrangement in which an individual health practitioner receives a capitation payment for a substantial portion of the cost of referrals[22] for that practitioner's patients. (Aggregated or pooled risk arrangements of, for example, five or more practitioners should be excluded from the prohibition in 4(a) and the requirements in 4(b).)

[21] Throughout this paper, the "state entity for regulation of managed care" means the Department of Corporations or its successor agency.
[22] For purposes of this discussion, referrals do not include services performed in a provider's office.

(b) The state entity for regulation of managed care should be required to review and approve the following types of incentive arrangements:

- where an individual health practitioner receives an incentive tied to a substantial portion of the cost of referrals of that practitioner's patients or
- where a very small group (e.g., fewer than five) receives such an incentive or a capitation payment for a substantial portion of the cost of referrals for the group's patients.

These arrangements should not be approved in the absence of a determination that there is a patient panel of sufficient size to spread risk, sufficient time over which the capitation or incentive applies, and adequate provisions to assure quality care and to protect against high risk cases through stop-loss or risk adjustment.

(c) The state entity for regulation of managed care should ensure that health practitioners who contract with health plans, who treat commercial patients, and who are at substantial financial risk (as currently defined by federal law) obtain stop-loss coverage, maintain sufficient reserves, or have other verifiable mechanisms for protecting against losses due to adverse risk. This provision should be administered in a manner that minimizes the administrative burden on practitioners and plans to the extent possible.

Recommendation No. 5
Sponsored purchasing groups, such as the Pacific Business Group on Health, and accreditation organizations, such as the National Committee for Quality Assurance, should review provider incentive compensation arrangements (including non-financial incentives) for the purpose of identifying best practices and practices in need of improvement, and seek to influence plan and provider groups accordingly. Particular attention should be paid to the promotion of risk factor measurement (e.g., morbidity and mortality rates) and risk adjustment and compensation arrangements that continue to include rewards for quality care, consumer satisfaction, and other non-financial factors.

Recommendation No. 6
An advisory group should be convened by the state entity for regulation of managed care, including major stakeholders[23] to review provider compensation arrangements, identify best practices, and practices in need of improvement, and advise the state entity for regulation of managed care regarding the need for changes in regulatory oversight.

Recommendation No. 7
The state entity for regulation of managed care should develop internal expertise in assessing compensation arrangements.

These recommendations were individually adopted by the Task Force as follows:
Recommendation No. 1 – Adopted 16-5
Recommendation No. 2 – Adopted 19-0
Recommendation No. 3 – Adopted 21-1
Recommendation No. 4 – Adopted 20-0
Recommendation No. 5 – Adopted 20-0
Recommendation No. 6 – Adopted 24-0
Recommendation No. 7 – Adopted 23-0

c. Physician-Patient Relationship

[23] The intention of the task force is that stakeholders include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.

Recommendation No. 1 Continuity with Providers

In addition to recommendations in the Consumer Information, Communication and Involvement paper (regarding research into the feasibility, utility and cost of creating a "Super Directory" of providers to ensure consumers know whether a particular provider or group is available to a member of a plan), the following recommendation could further address continuity issues:

(a) Existing law requires plans to have policies in place allowing for continuity of care when enrollees involuntarily change health plans. In addition, health plans and medical groups/IPAs should be required to enable consumers who are undergoing a course of treatment for a chronic, acute, or disabling condition (or who are in the second or third trimester of a pregnancy) when they involuntarily change health plans or when a provider is terminated by a plan or medical group/IPA (for other than cause) to continue seeing their current providers, at the patient's option, until the course of treatment (or postpartum care) is completed, up to a maximum of 90 days or until the patient's condition is such that the patient may be safely transitioned to a new provider.

(b) Providers who continue to treat such patients should be required to accept the plan's out-of-network or PPO rate for such care as payment in full, provide all necessary information to the plan for quality assurance purposes, and promptly transfer all medical records with patient authorization during the transition period.

Recommendation No. 2 Coordinating Role of the Primary Care Provider and Utilization Review

Health plans should be required to establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and that is life-threatening, degenerative, or disabling may receive an extended, prolonged, or permanent referral to a specialist. Such referrals should be conducted in a manner that maintains coordination of services (e.g., updating the PCP, sharing of medical records, agreeing on shared treatment plans, and agreeing on the respective roles of each practitioner).

Recommendation No. 3

If a patient is specifically assigned to or chooses a primary care provider and the provider, the provider's medical group/IPA or health plan directs that patient for an appointment to another physician, advanced practice nurse or physician assistant, the patient should be informed verbally and should consent prior to the appointment.

Recommendation No. 4 Quality Improvement Programs and Patient Confidentiality

As information relevant to quality of care becomes available, providers, regardless of financing and delivery system, should include relevant information at every level of care in the informed consent process. To the extent information is known, accurate, and reliable, a health care practitioner or hospital should make available upon request relevant information regarding his, her, or its experience and/or qualifications regarding the course of care a patient is considering.

Recommendation No. 5

(a) Federal reforms related to confidentiality of patient information and patient access and rights with respect to their medical records should be monitored, and state law should be consistent. In addition, state law should be reviewed to ensure confidentiality of individually-identifiable health care information and patient access and rights with respect to access to their medical records, while allowing health plans, provider groups, and providers to undertake activities required by law, including the provision of health care, outcomes research, risk adjustment and research to advance evidence-based medicine, payment for services, peer review, quality assurance, utilization review, and investigation of grievances. When disclosure is required, no greater amount of information

should be disclosed than is necessary to achieve the specific purpose of the disclosure. Otherwise, information should not be released unless authorized by patient consent or by law.

(b) No health plan or any of its contractors should be allowed to require an enrollee, as a condition for securing health care services, to sign a release or consent form which waives any individually-identifiable, medical information confidentiality protections for the purpose of using such information for commercial purposes.

These recommendations were individually adopted by the Task Force as follows:
Recommendation No. 1 – Adopted 26-0
Recommendation No. 2 – Adopted 24-0
Recommendation No. 3 – Adopted 25-0
Recommendation No. 4 – Adopted 25-0
Recommendation No. 5(a) – Adopted 23-0
Recommendation No. 5(b) – Adopted 21-0

d. Consumer Information, Communication and Involvement

* Recommendations for Consumer Information

Recommendation No. 1
The state entity(ies) for managed care[24] should create and update at least annually a "standard product description" in a format to facilitate direct comparison of health plans by consumers, designed with input from stakeholders,[25] in as non-political a process as possible. The CalPERS format could be considered as a model for this document. The state entity(ies) for regulation of managed care should require health plans to use the standard format to present information about any product they offer.

This standard benefit characteristics document should include a statement on how drug formulary decisions are made; should describe key elements of the plan's grievance procedure (including a description of any arbitration processes); should include independent (i.e. not self-reported) "exit polling" information on number disenrolling and primary reasons for disenrollment, when available; and should offer, for each plan or medical group/IPA with which the plan contracts, a brief but specific description of the referral and authorization process, and the process through which medical decisions are made. The state entity for regulating managed care should make these descriptions available to consumers at a nominal charge and should make this information available on the internet.

Recommendation No. 2
Health plans should be required to submit to the state entity(ies) for regulation of managed care information on approximately 10 major health conditions or illnesses requiring referrals to specialty centers (e.g. bone marrow transplants, coronary artery bypass grafts). Data should be reported on an annual basis for the prior year, and should include, for each condition or procedure: where and from which medical center the patient received care; how many of the procedure in question the center to which the patient was sent performed in that year; and, when risk-adjusted outcomes become available, outcomes measures. Data should be presented at the plan level, and where appropriate at the medical group or IPA level. Provisions should be made to ensure that data is presented in such a way that patient confidentiality is maintained. This information should be made available to consumers and organizations upon request.

Recommendation No. 3

[24] Throughout this paper, the term "state entity(ies) for managed care refers to DOC, DOI or their successor.
[25] The intention of the Task Force is that stakeholders include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans and purchasers.

Upon request by an enrollee or a member of the public, all health plans and medical group/IPAs should be required to make available at a nominal charge copies of any written treatment guidelines or authorization criteria for a given condition.[26]

Recommendation No. 4

Health plans should be required to update the information for their participating providers[27] on the internet continuously, and to update and make it available in print at specified locations at least quarterly. This information could then be made available to consumers through employee benefits offices, libraries and consumer advocacy and assistance organizations. Health plans should be required, upon member or potential enrollee request by telephone to provide information for their participating providers, e.g. to indicate whether a particular provider or provider group is a member of the plan's network, to indicate whether a participating primary care provider is accepting new patients or to provide a list of plan-approved specialists of a certain type in a certain geographic area.

The state entity(ies) for regulation of managed care should research and report on the feasibility, utility to the consumer and cost of creating a "Super Directory" of physicians and other primary care providers (e.g. advanced practice nurses), hospitals, clinics and medical group/IPAs participating in health plans, indicating which plans or groups they contract with. The purpose of this directory would be to ensure that consumers receive accurate information on whether a particular provider, group, hospital, or clinic will be available to him or her as a member of the plan. Primary care providers' entries should indicate which medical groups or IPAs they belong to, whether or not they are accepting new patients, and to what facilities or specialists their patients may be referred. This information should be made available to all consumers at the time of enrollment and renewal and to individual consumers at any time upon request.

Every effort should be made to minimize additional paper flow: paper copies of the Super Directory should be made available at a limited number of public sites, and an emphasis should be placed on development of electronic technologies for updating and providing information (e.g. automated telephone systems, internet).

Recommendation No. 5

The state entity(ies) for regulation of managed care's report on grievances should be expanded to include more detailed and meaningful information on grievances. The DOC currently provides information on complaints (in DOC terminology "requests for assistance" or RFAs) filed with the Department in writing, after the plan has had 60 days to resolve the problem. Current information provided by DOC includes a report on the number of complaints by type of complaint and plan.

The Task Force recommends that the report be expanded to include an indication of the severity and urgency (as defined by threat to life and health) of the complaint and whether and what action was taken by the plan and/or DOC in response to the complaint. This additional information is critical if consumers are to be able to use the complaint information in choosing a plan. This recommendation would provide an improvement in disclosure to consumers using information that is already available to DOC. Because measures of grievance severity and urgency may not have been developed by regulatory agencies or health plans to date, the Task Force recommends that a collaborative effort to develop such measures be undertaken.

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[26] Please note that The Task Force paper on Provider Financial Incentives presents several specific recommendations regarding disclosure of information about financial arrangements and payment mechanisms to consumers.

[27] Throughout this paper, the term "provider" refers to physicians and other appropriately licensed health professionals operating within their scope of practice.

See the Task Force paper on Dispute Resolution for additional recommendations on reporting and disclosure of grievance information, including a recommendation which provides for expansion and publication of public reports on complaints and grievances filed with health plans.

Recommendation No. 6

The state entity for regulation of managed care should encourage and support, to the extent possible in collaboration with private sector efforts, gathering of additional standardized patient satisfaction and quality data at the provider group level (for groups and IPAs exceeding a certain size threshold) as well as the plan level. This effort should not duplicate current initiatives, but should include health plans and groups who have not been included in surveys and reporting efforts to date and should expand on measures currently being collected. The PBGH/Medical Quality Commission "Physician Value Check" could be considered as a model for medical group/IPAs, and the FACCT[28] framework is one example of a model for collection of data at the plan level.

Recommendation No. 7

The Task Force recommends that employers who pay a portion of employees' health benefits coverage begin to increase awareness that dollars spent on health benefits are a part of employees' total compensation by including such payments as a separate line item on employee pay stubs. Employers may choose appropriate alternatives – such as reporting on total compensation and/or health insurance premiums for each employee – which achieve the goal of increasing employee awareness of the cost and value of health benefits. Employers should be encouraged to collect information from their employees on their experiences and problems with health plans and medical group/IPAs so that this information can be used in the plan negotiation process.

***** Recommendations for Consumer Involvement

Recommendation No. 1

The Task Force recommends the following revisions to requirements for health plan under Knox-Keene to increase consumer involvement in health plans' governance and/or operations:

(a) Establish *a governing body which is composed of at least one third members or enrollees and ensure that sufficient resources are made available to educate enrollee board members so that they can participate effectively. Enrollee board members should neither be employees of nor have a significant financial interest in the organization or competitor organization, or*

(b) Establish a member advisory committee(s) to ensure that members' values and needs are integrated into the design, implementation, operations and evaluation of the plan administrators. This committee(s) shall communicate and advocate for members' needs and serve as a resource for the governing body and HMO/plan administrators. It shall be responsible for establishing mechanisms and procedures for enrollees to express their views and concerns about the HMO/plan, including the viewpoints of enrollees who are members of vulnerable populations. The plan attributes/functions this committee(s) may address include but are not limited to: benefits and coverage, member communications, quality assurance, marketing and grievance resolution.

(c) Upon request by the state entity(ies) responsible for regulating managed care or accrediting organizations:

[28] The Foundation for Accountability (FACCT) is a not-for-profit coalition dedicated to helping consumers make better health care decisions. FACCT has released measures that attempt to create a relevant, comprehensive picture of quality of care for *specific conditions* – like asthma or diabetes, *lifestages* – like pediatrics or end of life, and *population status* – like health status over 65 or health risk behaviors. FACCT creates comparative information by organizing and weighting data from HEDIS, FACCT measurement sets, the Agency for Health Care Policy and Research's CAHPS, the Joint Commission on Accreditation of Health Care Organizations' ORYX and public health databases.

(i) Describe the mechanisms and lines of accountability used for obtaining and incorporating member feedback into policies and practices across all member-related departments/divisions, and

(ii) Demonstrate how member feedback has been incorporated into plan policy, operations and evaluation.

Recommendation No. 2
The Task Force recommends that purchasers and employer groups (including government entities) that contract for health care should exercise their bargaining power to encourage health plans to ensure that medical and other provider groups develop and utilize mechanisms of consumer feedback.

Recommendation No. 3
The Task Force recommends that accrediting bodies develop standards regarding health plans' and provider groups' utilization of validated, reasonable consumer feedback in policy development and implementation.

Recommendation No. 4
The Task Force encourages collaborative efforts among government, foundations, health plans, provider groups and purchasers to fund expansion of organized systems of consumer involvement.

Recommendation No. 5
The Task Force recommends that the state entity(ies) for regulation of managed care have member advisory committees responsible for ensuring that managed care plan members' values and needs are integrated into the collection of information from and regulation of managed care organizations.

These recommendations were individually adopted by the Task Force as follows:

Recommendations for Consumer Information:
Recommendation No. 1 – Adopted 20-0
Recommendation No. 2 – Adopted 22-0
Recommendation No. 3 -- Adopted 19-2
Recommendation No. 4 – Adopted 23-0
Recommendation No. 5 – Adopted 17-1
Recommendation No. 6 – Adopted 22-0
Recommendation No. 7 – Adopted 17-2

Recommendations for Consumer Involvement:
Recommendation No. 1 – Adopted 20-0
Recommendations No. 2 through 5 – Adopted 22-0

e. Improving the Delivery of Care and the Practice of Medicine

Recommendation No. 1 Modify Prior Authorization/Concurrent Review

(a) The Task Force recommends that health plans incorporate provider pre-credentialing and the use of practice guidelines, clinical pathways, retrospective review (as opposed to prior authorization/concurrent review) and outcomes-based data into their established utilization monitoring processes.

(b) The Task Force recommends to the health plans, medical groups/IPAs and their designees, that they develop utilization monitoring processes based on statistically valid data on patterns of care and patient outcomes, or professional consensus, that are sensitive to the needs of various populations, including vulnerable populations. These data sets or professional consensus may then form the basis on which alternatives to prior authorization can be based (See Task Force paper on New Quality Information Development).

(c) The Task Force recommends to the health plans and their designees that they develop and implement strategies that allow health care practitioners who demonstrate an exemplary practice profile to practice medicine with automatic approval for a defined scope of practice. A probationary period of up to, but not more than, two years may be employed to assess provider utilization in determining eligibility for automatic approval status. Plans may continue to require providers to obtain verification of eligibility, coverage and approval for the setting in which the procedure is to be performed.[29] Health plans may develop appropriate and periodic review mechanisms to ensure that providers continue to demonstrate an exemplary practice.

(d) The Task Force recommends to the health plans and their designees that they eliminate prior authorization and concurrent review for patients with catastrophic conditions being treated by pre-credentialed providers for which outcomes based protocols have been developed and broadly accepted (e.g., pediatric oncology).

[29] Eligibility is a distinct concept from coverage. Eligibility refers to the criteria that an employer uses to determine whether or not to offer health benefits to an employee as well as the criteria that a health plan uses to determine whether a patient is entitled to benefits through their employer. In the plan's case, the plan would want to know if a patient was still employed by Company A and whether the premium had been paid. Coverage refers to the list of benefits delineated by contract between Company A and the plan. This list usually includes hospital care, physician services, routine exams, maternity care, prescription drugs, etc.

(e) The Task Force recommends that there be a review and report by the year 2000 on how the private sector has modified the prior authorization/concurrent review process to recognize exemplary care or an equivalent modification. (The report should include consideration of whether the state entity(ies) for regulation of managed care[30] should consider making the necessary changes a requirement of health plan licensure or accreditation.)

(f) Where prior authorization/concurrent review is required, denials of care must include a review by appropriately qualified, credentialed individuals.

Recommendation No. 2 Improve Formulary Effectiveness

(a) Consumers should be ensured that they will be fully informed of their rights to prescription drugs offered by a health plan, and those rights should include, but not be limited to the following:

(1) All health plans and their designees (whether pharmaceutical benefits managers or medical groups) that offer prescription drug benefits and use a formulary, must periodically publish their formulary drug lists and make them available to any member of the public upon request subject to reasonable costs.

(2) All health plans and their designees (whether pharmaceutical benefits managers or medical groups) that offer prescription drug benefits and use a formulary must publish a description of the process by which their formulary is developed and reviewed.

(3) Health plans and their designees (whether pharmaceutical benefits managers or medical groups) must have in place, and make known to consumers and providers, timely exception processes by which a physician or a patient (with his or her physician's support) may secure quick approval for medically necessary non-formulary drugs.

(4) When a health plan removes a drug from its formulary, it should be required to allow the patient to continue receiving the removed drug for an ongoing condition unless the treating physician prescribes a new agent or the drug is no longer considered safe and effective for the patient's medical condition based on appropriate medical evidence.

(5) The state entity(ies) for regulation of managed care should be directed to investigate periodically and report publicly on health plan and contracting medical group compliance with these recommendations.

(b) Health plans that develop a formulary for their members should include input from practicing plan physicians with relevant expertise, input from specialty societies and other relevant data when composing the formulary.

Recommendation No. 3 Clarify Benefit Language in Health Insurance Contracts

(a) Create a "blue ribbon" public/private work group of major stakeholders[31] to study and recommend changing the benefit language in health plan contracts. The panel should have a state-wide strategy for implementing benefit language changes within two years. The state should require that implementation of these changes, where feasible, be phased-in within two subsequent years. Among the issues the panel should consider are:

[30] Throughout this paper, the term "state entity(ies) for regulation of managed care" refers to the Department of Corporations, the Department of Insurance, and its/their successor.

[31] The intention of the Task Force is that stakeholders include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.

- For most consumers the decision to pay for care is synonymous with the decision to receive care, since few consumers can afford to purchase most care out of pocket.

- Benefit definitions should consider the needs of seniors, children, individuals with disabilities and other vulnerable populations and should consider the objective of maximizing functional capacity and the inclusion of benefits to maintain function and to slow or prevent deterioration of function.

- Revisions of benefits criteria should consider the impact of reducing or eliminating coverage for care.

- Studies of the issues inherent in changing benefit language should consider the transition from vague, imprecise terms to language intended to maximize quality outcomes, health outcomes, functional outcomes and the scientific underpinnings of treatment decisions while controlling costs.

(b) The state entity(ies) for regulation of managed care should convene an appropriate panel representing all stakeholders and having appropriate clinical expertise to accept, catalogue and organize data concerning agreement on standard of care and medical appropriateness in reference to treatment issues.

This panel can review data presented as evidence-based or consensus-based pertaining to clinical modalities. By defining standard of care and medical appropriateness, this panel could also define experimental care and could help determine when sufficient data become available for a new clinical approach to transition treatments from experimental to clinical standard of practice. The panel could further catalyze needed clinical trials where appropriate data have yet to be developed for making such determinations.

This panel could also encourage all payors to identify and support experimental protocols in certain circumstances of life threatening or limiting illnesses.

These recommendations were individually adopted by the Task Force as follows:
Recommendation No. 1(a)-(d) – Adopted 28-0
Recommendation No. 1(e) – Adopted 27-0
Recommendation No. 1(f) – Adopted 28-0
Recommendation No. 2 – Adopted 28-0
Recommendation No. 3 – Adopted 20-1

f. Vulnerable Populations

Recommendation No. 1
The Task Force encourages purchasers to explore the feasibility of identifying and tracking the vulnerable populations among their membership, and reporting technologically feasible performance outcomes for these populations. Purchasers should work with DHS to determine how to develop most effectively the systems necessary to implement such identification, tracking, and reporting.

(a) Purchasers should explore the feasibility of providing incentives for plans to implement effectively by withholding a percent of the premium and paying plans on a sliding scale based on performance.

(b) Purchasers should explore the feasibility of developing common contract standards for plans to track, identify, and monitor performance outcomes for all vulnerable populations.

Recommendation No. 2

The Task Force encourages continuing DHS and other entities' efforts to study and pilot initiatives to assess the feasibility of the integration of acute, chronic, and long-term care services, as well as linkages to social services in the community for all plans.

Recommendation No. 3
The Task Force recommends that purchasers encourage those plans they contract with to work towards credentialing and certifying medical group/IPAs and providers based on their knowledge, sensitivity, skills, and cultural competence to serve vulnerable populations.

Recommendation No. 4 Application of Recommendations to the Medi-Cal/Medicare Populations
Resources should be provided to DHS to prepare annual reports for the Legislature and interested public on the quality of and access to care for Medi-Cal consumers and include the following topics:

(a) A comparison of the performance of plans within each Medi-Cal managed care county as well as among counties

(b) A comparison of networks among plans and between private pay and Medi-Cal commercial plans

(c) A comparison of access, quality, and cost indicators for Medi-Cal managed care patients with privately insured patients in California

(d) An evaluation of Medi-Cal consumers' (1) understanding of (2) use of and (3) access to managed care plans

(e) An analysis of the effectiveness of translated materials and the ability of plans to serve multi-lingual and multi-cultural consumers

(f) An analysis of provider continuity including analysis of impact of changes in Medi-Cal eligibility

(g) An analysis of patterns of default and disenrollment

The Task Force supports DHS' ongoing efforts to assess the impact of Medi-Cal managed care on the public health system.

Recommendation No. 5
Resources should be provided to DHS to prepare a periodic report for the Legislature and interested public on the impact of Medi-Cal managed care on the capacity of the public health system and other safety-net entities to provide care for uninsured patients. This should include county-by-county analyses of changes in access and quality for uninsured patients as well as analyses of changes in the institutional capacities of safety-net providers.

Recommendation No. 6
Resources should be provided to DHS to prepare a periodic report for the Legislature and interested public on the impact of Medi-Cal managed care on the capacity of public health entities to continue their work in population health including their capacity to track epidemiological trends and to do population-based health education.

These recommendations were individually adopted by the Task Force as follows:
Recommendation No.1 – Adopted 21-0

Recommendation No.2 – Adopted 22-0
Recommendation No.3 – Adopted 23-0
Recommendation No.4 -- Adopted 17-2
Recommendation No.5 -- Adopted 16-4
Recommendation No.6 -- Adopted 16-4

g. Integration and Coordination of Care – Case Study on Women's Health

Recommendation No. 1
Managed care organizations (MCOs) should be encouraged to coordinate and integrate care around the needs of members. Purchasers and accrediting organizations should work with advocacy groups to define member survey questions that measure the extent to which MCOs are effectively integrating and coordinating members' care, including services exclusive to women and incorporating measures of under and over-utilization. Because HEDIS measures are used widely by purchasers and consumers to assess health plan performance, the elements included strongly influence health plans' priorities in service delivery and quality improvement, and they serve as important leverage points for influencing both plan and provider behavior. MCOs should involve consumers and advocates in developing improved gender sensitive indicators for HEDIS and other quality improvement tools.

Recommendation No. 2
Recognizing that members, particularly women and adolescents, are likely to forego care because of issues of scheduling and confidentiality, managed care organizations should address these specifically as issues of access and should survey members to determine whether they feel that services are accessible and confidential.

Recommendation No. 3
When managed care organizations refer members to community-based clinics for services not available elsewhere within the plan (or recognize that many of their members are self-referring to these facilities), they should be encouraged to provide an option that allows reimbursement for necessary primary and preventive care delivered at these sites.

Recommendation No. 4
(a) Health plans should be required by the state entity responsible for regulating managed care to provide information on coverage and benefits to all plan enrollees (not only to the primary plan subscriber), upon request, to ensure that those plan members covered as dependents are aware of the services available to them.

(b) This coverage and benefits information should include full disclosure of limitations on reproductive health services and referrals.

Recommendation No. 5
The division between primary care and routine reproductive care for women results in underutilization of necessary preventive services, fragmentation of services, unnecessary duplication of services, inconvenience and cost for members and increased costs for insurers. To alleviate these problems:

(a) Primary care training programs should incorporate the full range of primary health needs of men and women, and should prepare practitioners or design practitioner teams to provide for the totality of these needs.

(b) Managed care organizations should ensure that primary care practitioners or teams made available to members are capable of providing the full range of necessary primary care services to avoid duplication that is costly to both plans and members. Managed Care

Organizations should be encouraged to require generalists who wish to provide primary care to women to demonstrate competency in the basic aspects of gynecological care such as breast and pelvic exam, contraceptive management, and initial management of common gynecological problems, as well as sensitivity to the unique needs and concerns of women.

(c) Plans shall be required to allow women direct access to their reproductive health care providers, be they physicians, nurse practitioners, certified nurse midwives, or other appropriately credentialed advanced practice professionals. The Task Force strongly urges plans to construct direct access arrangements in a manner that permits and encourages coordination and integration of services among an individual's health care providers (e.g. provisions should be made to ensure that providers agree upon division of tasks/treatment areas, communicate their findings and treatment advice with one another, and update and share patient records) while maintaining patient confidentiality.

Recommendation No. 6

The Task Force encourages collaboration between the public and private sectors on development of consistent standards and evidence-based, gender-specific practice guidelines.

These recommendations were individually adopted by the Task Force as follows:
Recommendations No.s 1 through 5(b) – Adopted 18-0
Recommendation No. 5c) – Adopted 18-0
Recommendation No. 6 -- Adopted 18-0